Trophy Club Family Medicine
945 Trophy Club Drive
Trophy Club, TX 76262
817-430-9111

Welcome to Your Medical Home

A medical home is a team approach providing total healthcare. Your medical home will include your healthcare provider, others who support you, and yourself.

Why is it important to have a Medical Home team?

Your medical home can:

1. Help you manage your healthcare by using evidence-based care and self-management support
2. Help answer your health questions
3. Listen to your concerns
4. Work with other medical experts if necessary
5. Coordinate your care through additional services
6. Encourage you to play an active part in your own healthcare

What can YOU do to help?

1. Be an active team player
   a. Talk with your team about your health questions
   b. Share your past healthcare successes and challenges
   c. Tell your team about other healthcare professionals who care for you
   d. Tell your team how you feel about the care you are getting from them
2. Take care of your health
   a. Follow the healthcare plan you and your team have talked about. Make sure you understand how to follow the plan. Set goals you can reach. Once you begin to see results, you and your team can discuss adding new goals.
3. Talk openly with your team
   a. Tell your team if you are having trouble sticking with your care plan
   b. Speak up if your care plan is not working. Tell your team what is not working so together you can make changes if needed.

WE HAVE OUTLINED OUR OFFICE POLICIES THAT HELP US SERVE YOU BETTER.
Please read these carefully and completely and sign below

Clinic Hours
Monday – Thursday 8:00am- 12:00pm and 1:00pm- 6:00pm
Fridays 8:00am – 12:00pm and 1:00pm – 5:00pm

Appointments
Appointments can be made during regular business hours. If you are unable to keep your appointment, you must contact us within 24 hours of your appointment or there will be a $25 minimum cancellation charge depending on the type of appointment you had scheduled. If you arrive late for your appointment, we will make every attempt to see you; however your appointment may have to be rescheduled.

Telephone Calls/Web messages for the Providers or Medical Assistants
Our phones are answered and web messages are checked throughout the day during our normal business hours. A medical assistant will return all calls/messages received before 4:00pm by the end of day. Calls/messages received after 4:00pm will be returned by end of the next business morning.

After Hours Emergency Calls
Our providers are always available after office hours, 5:00pm to 8:30am, for emergency call. Night and weekend coverage is shared with all our providers. Call our main number 817-430-9111 and follow instructions to reach provider on call. In a life-threatening situation, go to the nearest Emergency Room or call 911.

Prescriptions
Your medical record is needed to determine whether a refill should be issued, therefore refills cannot be approved after normal business hours or weekends. During your visit your Provider will give you prescriptions in amounts to last until you need to be seen again. Follow up appointments are scheduled so that your provider can monitor your condition and adjust medications accordingly. To ensure appointment availability, please make this appointment at the time of your current visit or at the time you get your last refill. Prescription requests received after 4pm will be processes by the end of the next business day. We do not refill medications after hours or weekends. If you do find yourself in need of more medication prior to your appointment, please call your pharmacy, who will call us for any additional refills. Please allow 24 to 72 hours to approve or deny any refill. ***Our office has a NO SHOW, NO MEDICATION policy. Failure to show for your appointment will result in a denial for medication.***

Referrals
Some managed care plans require your primary care doctor to obtain authorization to be referred to a specialist. If your managed care plan requires this, we will obtain authorization from your insurance company within 3 business days. Please do not make an appointment with the specialist until you have received a call from our referral department or you receive your referral in the mail.

Outpatient Procedures
We will obtain authorization from your insurance company and you will be contacted by the facility to which you are being sent to within 5 business days to schedule your procedure. Your results will be discussed at your follow-up appointment.

Lab Results
Please sign up for portal access so you can receive your results quickly.

- Acute illness lab results
    - All lab results will be discussed at a follow-up appointment, or a secure message will be sent to your portal.
- Chronic disease results:
    - Labs are drawn 1 week prior to your appointment with the Provider if there is a standing order. Results are reviewed at your follow-up appointment
- Surgical Biopsy Result:
    - You will either be sent a secure message in 10-14 days or the results will be reviewed during your suture removal appointment.

Treatment of a Minor
A minor is person under the age of 18 who has never been married and never been declared an adult by a court. Generally, minors do not have the legal capacity to consent to medical treatment.

- In order for us to treat a minor we must have written consent from a parent or legal guardian including a statement as to the nature of the medical treatment to be given on a specific day.
- Minors age 15 and under MUST be accompanied by an adult (18 years or older)

With the written consent, we will perform the:

- Examination
- X-rays
- Noninvasive procedures
- Other testing

We will not perform:

- Invasive procedures
- Immunizations
- Injections
- Lab Draws

Immunizations
Please be aware that we need an updated immunization record for all patients. We will be glad to copy it and return the original to you.

Managed Care
We accept dozens of insurance plans, including Medicare and Medigap carriers with various deductibles, co-pays, and coverage's. We cannot know all of the coverage limitations and rules of your plan. It is important that you read and understand the provisions of your insurance policy. Please bring your insurance card along with a picture I.D. to every visit.

Responsibility for ensuring Insurance Coverage
You are responsible for ensuring that we are providers on your insurance plan and for knowing what services you have coverage for including but not limited to

- Annual deductible
- Co-payments
- Weight control
- Psychological or cosmetic services
- X-rays
- Procedures

You will be responsible for paying all services not covered by your insurance plan. We will bill both your primary and secondary insurance plans for contracted plans. You may be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by **Medicare or Tricare.** If you have Medicare as well as secondary coverage plan that are not Medigap, we will file a claim to your secondary/supplemental carrier. If no payment is received from them within 45 days after we filed a claim, you will be sent a bill for the balance. In the event that we are not aware if a charge is not covered by your plan, your balances will be billed after we obtain a denial form from your insurance carrier.

Non Contracted Relationships
For non contracted relationships we will bill both the primary and secondary insurance. If we do not receive payment with 45 days of filing, you will be billed for the entire amount. Payment will be due 10 days after receipt of statement. If you **only** have a primary insurance you will be asked to prepay 35% of the entire bill. Any amount not paid by your insurance company will be billed to you.

Private Pay Patients
Payment is due at time of services. If you are unable to pay for services **in full** you must arrange a payment plan prior to your appointment thru our billing department.

All payments are due at check out.

Motor Vehicle Accidents (MVA)
We do not file charges to MVA ***insurance policies***. All charges for services rendered due to a MVA will be filed with your insurance company; any remaining balance not covered will be due in full at the time of your visit. You will need to submit your charges and seek reimbursement from the MVA insurance company.

Third Party Liability
"Third Party Liability" means that someone else's insurance is to cover your illness/injury. For example, a fall at a grocery store, where the grocery store's insurance will pay your medical bills. We do not file charges for payment to attorneys or any other third party payer. All charges for services rendered are payable in full at the time of your visit. You will need to submit your charges and seek reimbursement from the third party insurance payer.

Workman's Compensation
We do not file workman's compensation insurance; therefore we cannot treat you for any work related to illness or injury. Due to State Laws, you could be denied benefits if you claim your condition is not work related but actually is.

Letters and Forms
There will be $25 charge for any letter the physician has to initiate, if not in conjunction with an office visit. Any forms such as insurance application, disability, adoption, employer forms, or family medical leave will cost $25.

Your signature signifies that you have read and understand the above pages and your responsibility regarding charges incurred in this office.

_____ _____

Patient Signature (or Guardian) Date

TROPHY CLUB FAMILY MEDICINE

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Primary language	Ethnicity	Birth date: / /	Age:	Sex: ❑ M ❑ F

Mailing Address:	Social Security no.:	Best Phone # to Reach you at: ( )

Preferred Pharmacy	Pharmacy Address	Pharmacy Phone Number

Chose clinic because/Referred to clinic by (please check one box):
❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

PLEASE PROVIDE EMAIL ADDRESS FOR OUR SECURE PATIENT PORTAL WEBSITE:

INSURANCE INFORMATION CLASS

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary insurance

Secondary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:
		/ /		

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

DO WE HAVE PERMISSION TO:

Leave a message on your answering machine at home or on your cell phone. { } Yes { } No
Leave a message at your place of employment? { } Yes { } No
Discuss your medical condition with any member of your household? { } Yes { } No

IF YES: Name Relationship to Patient

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Trophy Club Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

TROPHY CLUB FAMILY MEDICINE

Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

a) Sharing of Information for Purposes of Treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with the quality care and the educational/wellness programs specified by my insurance plan.

b) Sharing of Information for Purposes of Payment: You will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives [including, but not limited to benefit determination and utilization review] as well as your representatives involved in the building process [including, but not limited to claims representatives, data warehouses, billing companies].

c) Sharing of Information for Purposes of Operations: You will share all information necessary for ongoing operations in this office, including [but not limited to] the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given, I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

_____

Patient Name (Please Print) Date

_____

Patient Signature (or Guardian, if minor)

_____

Witness (optional) Date

TROPHY CLUB FAMILY MEDICINE

Welcome to Trophy Club Family Medicine!

Date :_____

Please let us know how you first heard about our office? What made you pick up the phone and call us to make an appointment? Select all that apply.

_____ Word of mouth: Friend, Neighbor, Co-Worker, Family, etc.

_____ Drive by or saw sign/building

_____ Insurance website

_____ Website: what search engine did you use: Google, Yahoo, Bing, other:

What did you search for? _____

Why did you change from your current doctor/clinic?

_____ New to the area

_____ Didn't have other current doctor/clinic

_____ Insurance change: Doctor no longer on plan, got a new plan, etc.

_____ Unhappy with last doctor/clinic

Why? _____

_____

_____ Other _____

Trophy Club Family Medicine (817) 430-9111 New Patient rev 11/17

Name _____DOB ___/___/___ Date ___/___/___

Please list ALL current medications, vitamins, herbs or non-food supplements

Medication	Dose	Frequency		Medication	Dose	Frequency

Any chronic or recurring conditions?

Any hospitalizations or major illnesses? Any surgeries (including wisdom teeth)?

Please list any specialists that you have seen in the past few years and why.

_____

_____

_____

_____

_____

Allergies or reactions to medications, or other agents

Medication	Reaction or side effect		Medication	Reaction or side effect

Tobacco use

☐ Never smoked ☐ Current smoker ☐ Former smoker, quit date: _____

Total history of use: Average packs/day: ____ for #of years: ____.

Other tobacco: ☐ pipe ☐ cigar ☐ snuff ☐ chew ☐ other

Alcohol use

Drinks in a typical week _____

Does your drinking worry you or others? ☐ yes ☐ no

Drug use

Have you ever used recreational drugs? ☐ No ☐ Yes: _____

Still using? ☐ No ☐ Yes: _____

Name _____ DOB ____/____/____ Date____/___/____

Average daily caffeine use

coffee: (6oz = 1 serving)_____ # tea_____ # cans of soda_____ # energy drinks_____

Exercise: Any regular exercise? ☐ Yes ☐ No. Type, hours per week:_____

Current occupation: _____ **Occupational hazards**:_____

Average hours worked weekly including commute: _____

Activities and hobbies:_____

Education completed: ☐ grade ☐ high ☐ trade ☐ college ☐ masters ☐ graduate

Marital status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed/er ☐ co-habitating

Sexually active ☐ Yes ☐ No

Sex partners are ☐ male ☐ female

Contraception and protection: Birth control method: _____

Have you ever had any sexually transmitted diseases? ☐ Yes ☐ No

If yes, please explain: _____

History of blood transfusion? ☐ Yes ☐ No **Any tattoos?** ☐ Yes ☐ No

Women's gynecologic history:

pregnancies:___ # abortions: ___ # miscarriages:___ # c-sections ___ # vaginal deliveries: ___

1st day, most recent period_____ Age at onset of periods: _____

Frequency of periods: _____ Length of periods: _____

Ever had an abnormal pap? ☐ Yes ☐ No

Personal and Family history

Please note major medical conditions of your family members.

Please be as specific as possible.

Mom: _____

_____

Dad: _____

_____

Children: _____

_____

Other relatives: _____

_____

_____

Name _____ DOB ____/____/____ Date____/___/____

Review of Systems (this is to check for past or recurring issues)

Constitutional:	Y	N
Chronic poor sleep		
Chronic fatigue, excessive sleepiness		
Chronic pain		
Unexplained weight loss or gain		
Neurologic:	Y	N
Recurring dizziness		
Headaches more than 3 per month		
Numbness or tingling		
Ever had seizures		
Significant memory loss		
Eyes/ears/nose/mouth:	Y	N
Eye issues (other than glasses)		
Recurring sinus infections		
Loss of hearing, ringing in ear		
Seasonal allergies		
Difficulty swallowing		
Respiratory:	Y	N
Recurring shortness of breath		
Frequent cough or wheezing		
Frequent or loud snoring		
Recurring lung infections		
Cardiovascular:	Y	N
Ever had bad chest pain		
High blood pressure		
High cholesterol or lipids		
Gastrointestinal:	Y	N
Recurring abdominal pain		
Recurring nausea, upset stomach		
Indigestion/heartburn		
Irregular bowel movements (normal is 3-14/week without straining)		
Difficulty swallowing; choking episodes		

Musculoskeletal:	Y	N
Frequent joint or bone pain		
Unexplained muscle pain		
Constant urge to move legs		
Leg swelling		
Skin:	Y	N
Recurring rash, itch		
Non-healing lesions, wounds		
Unexplained lumps or bumps		
Endocrine:	Y	N
Recurring irregular periods or cramps		
Excessive thirst, hunger		
Often feel too hot or cold		
Genitourinary:	Y	N
Difficulty starting stream		
Frequent or small voids		
Urinate more than twice per night		
Leaking urine		
Hematologic/Immunologic:	Y	N
History of non-pregnancy anemia		
Ever had blood clot, clotting disorder		
Ever had severe allergic reaction		
Psychiatric:	Y	N
Ever had major depression		
Anxiety, excessive worrying		
Frequent mood swings		
Sexual:	Y	N
Sexually active		
Erectile or vaginal issues		
Poor performance or low sex drive		
Breast or testicular lumps		
Other:		
Other:		